

finding, and parents were reassured and advised to give paracetamol and ensure adequate fluid intake. After presentation to the hospital, one child turned out to have a viral illness, while the other had pneumococcal meningitis and required a prolonged hospital stay. The helplines have since addressed the issue by updating their protocol and providing further training for their nurses.

In both these cases an important sign, that is the bulging fontanelle, was missed, and parents were falsely reassured. In medical school, presentation of meningitis in children is well-rehearsed, including all rare and non-specific presentations, to ensure this disastrous condition is recognised early. I doubt that any doctor would have missed this sign. I would encourage all primary care trusts to review their out-of-hours service, and to review protocols and guidelines they hold on children presenting with non-specific febrile illness, and in particular, include this subtle but important sign. I would like to advocate a low threshold for babies and infants to be reviewed by a doctor in any case.

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## An observational study of escalator ambulation

In an age of increasing overweight and obesity it is important that we perform purposeful exercise and promote it to our patients. I attended the American College of Cardiology meeting in Orlando held over 6–9 March 2005. To see if physicians would 'practice what they preach', I sat at the bottom of an escalator and recorded the activity of attenders on the escalator over a 1 hour period of time (11:47 am to 12:47pm 8 March 2005). Two-thirds of the 234 users of the escalators made no movement other than getting on or off the

escalator despite there being no obvious impediment to them doing so. We ask our patients to change their lifestyles and yet clearly fail to do so ourselves.

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## Homeopathy — a response

I hope I may be allowed to reply to the several letters<sup>1–4</sup> commenting on my deliberately provocative personal column on homeopathy.<sup>5</sup> All four authors assert their belief that homeopathy 'works', two of them making the claim that the fact that it works in babies and animals proves that this is more than a placebo effect. None of them cites any objective source of evidence for their beliefs, nor do they address the main point of my piece, which was to try to lay out the extraordinary, and to me still literally incredible, rationale that lies at the heart of homeopathic practice.

I agree wholeheartedly with Peter Hanrath and Andrew Hillam regarding the direction of much of our current target- and contract-driven practice, as I hope my more recent piece on statins illustrates.<sup>6</sup> I have no quarrel with the use of complementary therapies per se, but I do think that such therapies should be subject to the same scientific scrutiny as is now expected of conventional therapies. As a novice in acupuncture I am well aware that much of its benefit is likely to be due to non-specific effects, and I don't agonise too much over its probable additional specific, neurologically-mediated mechanisms — but I welcome research that explores both these areas. It is my firm belief that the scientific approach can be brought to bear on the still mystifying power of such factors as suggestion, the personality of both doctor and patient, the nature of the relationship between them and so on.

Nigel Williams (in his letter)<sup>1</sup> mentions

a meta-analysis<sup>7</sup> in the *Lancet* in 1997. More recently *Bandolier*<sup>8</sup> published a 'systematic review of systematic reviews' of homeopathy and concluded as follows: 'Much of the argument about homeopathy ends up being about trivial differences of little or no clinical relevance. Until large well-conducted trials tell us differently, the conclusion is that homeopathy does not work ...'. A search of the *Bandolier* website<sup>9</sup> leads to a number of commentaries on trials of homeopathy, not one of them showing any clear evidence of benefit. *Clinical Evidence*<sup>10</sup> contains only one reference, that being a negative report of two RCTs for homeopathic treatment of warts. The *Cochrane* collaboration<sup>11</sup> adds nothing further.

Finally — and hot off the press — Shang *et al* from Switzerland<sup>12</sup> report on a comparison of 110 homeopathy trials and 110 matched trials of conventional treatments. They found insignificant evidence for a specific effect of homeopathic remedies, and strong evidence for specific effects of conventional interventions. They conclude that, 'This finding is compatible with the notion that the effects of homeopathy are placebo effects'.

It is this absence of evidence for any specific effect of homeopathic remedies that led me to use the word 'deception' in the title of my column; it is the absence of harm, and the apparent non-specific beneficial effects of the homeopathic approach that made me qualify it as 'benign'. None of your correspondents has convinced me that this is an unfair description.

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## Turbulent times in Italian general practice

I have to stress the point that the Italian government is trying to combine general practice and emergency service and out-of-hours services into single primary care units that provide 24-hour cover.

From outside Italy, it could be read as the way forward for primary care groups or primary care trusts, because we see in the UK that GPs work in partnerships in the NHS.

In Italy it will be totally different because single primary care units are not financially and contractually going to be trusts, but that every GP would remain in a quasi-subordinated profile with the local health service as the real decision makers for their future professional contract. GPs' careers would depend upon local health service strategies and expenses profiles.

GPs provide 24-hour cover and this is thought to be good for all patients and for quality of care, despite a lack of evidence and experimental research.

Take in mind this: when the new contract in the UK abolishes out-of-hours care ... here we see, after 25 years of emergency services, that GPs, some approaching retirement age, are asked to work nights and weekends ... or are pushed to ask for early retirement — if

pensions will be still paid to physicians ...<sup>1</sup>

Also, this big change proposed may force GPs to close their solo practices after years of work spent managing them.

Again, there are no plans (apparently ... or an underground network of interests could be in gestation) to consider structured places where to put these groups of doctors who are really pushed (obliged for survival) to work together and to change their style of work and life in such a strong and quick way.

This 'investment' in changes is being made in a national context without an apparent new contract for years, with an economic downturn and increasing burn-out, as indicated in the international research (only Hungary and Bulgaria got worse results in this, according to a presentation by Petrazzuoli *et al* at the WONCA European Congress in Amsterdam in June 2004). An increasing number of GPs are looking at the UK's NHS International Recruitment going around Italy and collecting GPs who are free to leave the country.

Substantially, this change is going to be imposed without total consultation of GPs. This lack of consultation is taking place despite a national economic recession and without any real financing of the public primary care setting unlike other countries such as the UK, because the political powers don't believe in a real professional relevance and leadership for general practice. In Italy not one research department of general practice exists.

The new kind of general practice created by the forthcoming changes (anonymous and without continuity care for patients) would be a local sub-product of hospitals. Devolution of local trusts with different speeds and different contractual powers is the way to kill (slowly but inexorably) GPs as free contractors and advocates for their patients, along with the public health system.

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## Table mountains

Am I alone in thinking that the tables accompanying the original research articles in the August journal (Vol 55, issue 517) were heavy going? Particularly when trying to illustrate symptom prevalence changes over time (page 599), I would very much like a pretty picture rather than a table (albeit a cheery yellow). What is the *BJGP*'s policy on the use of illustrations and graphics? Or have I just revealed myself to be a lightweight and rather uncritical reader?

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## Editor's Comment

The *BJGP* tries to make the data as simple and comprehensible as possible, while still having enough for readers to judge the reliability of the results and interpretation being claimed by the authors. When the dataset is large we do sometimes publish the full table in the electronic journal, and a simpler version (or none at all) in the hardcopy version. This paper did rely on large tables, but it was impossible to truncate them or confine them to the electronic journal, given the nature of the study. We can, perhaps, take some comfort that this is the first time in several years that this criticism has been made. We have every confidence in Dr Harnell's intellectual capacities as a reader.

### David Jewell

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